Exhibit A

Administrative Rules of Monta

MEDICAID PRIMARY CARE SERVICES 37.86.1105

37.86.1105 OUTPATIENT DRUGS, REIMBURSEMENT (1) Drugs will be paid for on the basis of the Montana "estimated acquisition cost" or the "maximum allowable cost", plus a dispensing fee established by the department, or the provider's "usual and customary charge", whichever is lower; except that the "maximum allowable cost" limitation shall not apply in those cases where a physician or other licensed practitioner who is authorized by law to prescribe drugs and is recognized by the Medicaid program certifies in their own handwriting that in their medical judgement a specific brand name drug is medically necessary for a particular patient. An example of an acceptable certification would be the notation "brand necessary" or "brand required". A check-off box on a form or a rubber stamp is not acceptable.

(2) The dispensing fee for filling prescriptions shall be determined for each pharmacy provider annually.

(a) The dispensing fee is based on the pharmacy's average cost of filling prescriptions. The average cost of filling a prescription will be based on the direct and indirect costs that can be allocated to the cost of the prescription department and that of filling a prescription, as determined from the Montana Dispensing Fee Questionnaire. A provider's failure to submit, upon request, the dispensing fee questionnaire properly completed will result in the assignment of the minimum dispensing fee offered. A copy of the Montana Dispensing Fee Questionnaire is available upon request from the department.

(b) The dispensing fees assigned shall range between a minimum of $2.00 and a maximum of $4.70.

(c) Out-of-state providers will be assigned a $3.50 dispensing fee.

(d) If the individual provider's usual and customary average dispensing fee for filling prescription is less than the foregoing method of determining the dispensing fee, then the lesser dispensing fee shall be applied in the computation of the payment to the pharmacy provider.

(3) In-state pharmacy providers that are new to the Montana Medicaid program will be assigned an interim $3.50 dispensing fee until a dispensing fee questionnaire, as provided in (2), can be completed for six months of operation. At that time, a new dispensing fee will be assigned which will be the lower of the dispensing fee calculated in accordance with (2) for the pharmacy or the $4.70 dispensing fee. Failure to comply with the six months dispensing fee questionnaire requirement will result in assignment of a dispensing fee of $2.00.

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(4) "Unit dose" prescriptions will be paid by a separate dispensing fee of $0.75. This "unit dose" dispensing fee will offset the additional cost of packaging supplies and materials which are directly related to filling "unit dose" prescriptions by the individual pharmacy and is in addition to the regular dispensing fee allowed. Only one unit dose dispensing fee will be allowed each month for each prescribed medication. A dispensing fee will not be paid for a unit dose prescription packaged by the drug manufacturer.

(5) Reimbursement for outpatient drugs provided to Medicaid recipients in state institutions shall be as follows:

(a) for institutions participating in the state contract for pharmacy services, the rates agreed to in that contract. Such reimbursement shall not exceed, in the aggregate, reimbursement under (1); or

(b) for institutions not participating in the state contract for pharmacy services, the actual cost of the drug and dispensing fee. Such reimbursement shall not exceed, in the aggregate, reimbursement under (1).

(6) Full-benefit dual eligible recipients qualify for pharmaceutical drug coverage under Medicare Part D prescription drug plans (PDPs) on January 1, 2006 under 42 USC 1302, 1395w-101 through 1395w-152 (2005), the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). For purposes of the MMA and this rule, the term full-benefit dual eligible has the same meaning as stated in 42 CFR 423.772.

(7) The MMA allows PDPs to exclude from coverage the drug classes listed in 42 USC 1396r-8(d)(2) (2005). Montana Medicaid may also exclude these drugs and has chosen to do so except for the prescription and nonprescription drugs identified on the department's drug formulary. On January 1, 2006, Montana Medicaid's reimbursement for outpatient drugs provided to full-benefit dual eligible recipients, for whom third party payment is not available, will be limited to the excluded drugs identified on the department's drug formulary. (History: 53-2-201, 53-6-113, MCA; IMP, 53-6-101, 53-6-113, 53-6-141, MCA; NEW, 1980 MAR p. 2978, Eff. 11/29/80; AMD, 1983 MAR p. 607, Eff. 5/27/83; AMD, 1986 MAR p. 1967, Eff. 12/1/86; AMD, 1987 MAR p. 895, Eff. 7/1/87; AMD, 1988 MAR p. 753, Eff. 5/1/88; AMD, 1989 MAR p. 879, Eff. 7/1/89; AMD, 1990 MAR p. 1481, Eff. 7/27/90; AMD, 1998 MAR p. 495, Eff. 2/13/98; AMD, 1998 MAR p. 2168, Eff. 8/14/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 3176, Eff. 11/10/00; AMD, 2002 MAR p. 1788, Eff. 6/28/02; AMD, 2006 MAR p. 227, Eff. 1/27/06.)

Subchapters 12 and 13 reserved

MEDICAID PRIMARY CARE SERVICES 37.86.1101

Subchapter 11

Outpatient Drug Services

37.86.1101 OUTPATIENT DRUGS, DEFINITIONS (1) "Estimated acquisition cost (EAC)" means the cost of drugs for which no maximum allowable cost (MAC) price has been determined. The EAC is the department's best estimate of what price providers are generally paying in the state for a drug in the package size providers buy most frequently. The EAC for a drug is:

(a) the direct price (DP) charged by manufacturers to retailers;

(b) if there is no available DP for a drug or the department determines that the DP is not available to providers in the state, the EAC is the average wholesale price (AWP) less 15%; or

(c) the department may set an allowable acquisition cost for specified drugs or drug categories when the department determines that acquisition cost is lower than (1)(a) or (b) based on data provided by the drug pricing file contractor.

(2) "Legend drugs" means drugs that federal law prohibits dispensing without a prescription.

(3) "Maximum allowable cost (MAC)" means the upper limit the department will pay for multi-source drugs. In order to establish base prices for calculating the maximum allowable cost, the department hereby adopts and incorporates by reference the methodology for limits of payment set forth in 42 CFR 447.331 and 447.332 (1996). The maximum allowable cost for multi-source drugs will not exceed the total of the dispensing fee established by the department and an amount that is equal to the price established under the methodology set forth in 42 CFR 447.331 and 447.332 for the least costly therapeutic equivalent that can be purchased by pharmacists in quantities of 100 tablets or capsules or, in the case of liquids, the commonly listed size. If the drug is not commonly available in quantities of 100, the package size commonly listed will be the accepted quantity. A copy of the above-cited regulations may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(4) "Outpatient drugs" means drugs which are obtained outside of a hospital. (History: 53-2-201, 53-6-113, MCA; IMP , 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW , 1998 MAR p. 495, Eff. 2/13/98; TRANS , from SRS, 2000 MAR p. 481; AMD , 2000 MAR p. 2313, Eff. 8/25/00; AMD , 2002 MAR p. 1788, Eff. 6/28/02.)

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